



DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-01

Agencies providing wellness programs to clients

Issued Jan. 27, 2010

To: All licensed insurers, all licensed producers, agencies, and third-party administrators, all trade associations, and the public.

From: John M. Huff, Director

Re: Health insurance and producer provided wellness programs – rebating

Rescinded and Inoperative

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) recently received questions regarding whether insurance producers may offer wellness programs, including, but not limited to, the use of health clubs or exercise equipment, providing personal trainers and other personnel trained to provide wellness services and counseling, etc. without additional charge. The offer is made by producers and agencies to an employer group if the group purchases its health insurance plan from the producer or agency, the producer or agency will include a personalized wellness plan to the group free of charge. The program is offered in addition to the benefits included in the written policy. The group pays only for the health insurance plan. The producer or agency covers the cost of the wellness program out of the commission it receives for selling the insurance coverage.

The DIFP recognizes that worksite wellness program provide benefits for both the employer and employees. They not only reduce demand for medical services, helping companies reduce their health-care costs, they also provide intrinsic economic benefits such as reducing absenteeism and on-the-job injuries, as well as workers' compensation and disability-management costs. Providing these programs assist employees in adopting and maintaining healthy lifestyles, which, in addition to boosting worker morale, lead to increased productivity.

This bulletin provides the DIFP's position as it relates to the applicability of the Unfair Trade Practices Act (§§375.930 – 375.948, RSMo), specifically the provision in §375.936(9), RSMo, relating to rebates, and reminds producers and other regulated entities of their responsibility to comply with Missouri law.

Missouri law prohibits an insurance company, insurance producer or agency generally from providing inducements to the sale that are not provided for in the insurance contract. Because the additional wellness programs offered by the producers and agencies are not provided for in the insurance contract being sold to the employer groups, they constitute valuable consideration and an unlawful inducement or rebate in violation of the Unfair Trade Practices Act (Act), regardless of whether they are provided directly or indirectly by the regulated entities.

Section 375.936(9), RSMo, defines a “rebate” as

“knowingly permitting or offering to make or making any contract of ... accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or ... or anything of value whatsoever not specified in the contract.”

If the Director determines or believes that an insurer, which under §375.932(3), RSMo, includes individual producers, “has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice, or course of business constituting a violation” of the Act, the director may take administrative or civil enforcement action or relief authorized under” either §374.046 or §374.048, RSMo. §375.942, RSMo. Each practice in violation of the Act is deemed a level two violation under §374.049, RSMo. *Id.* The Director can also take action under §375.940, RSMo, by filing a statement of charges against the “person or insurer” believed to have engaged in “any unfair method of competition,” act or practice violating the Act.

Because the wellness programs offered by the producers or agencies are not provided in the insurance contract, they would constitute valuable consideration and an unlawful inducement or rebate, in violation of the prohibitions set out in §375.936(9), RSMo. For essentially the same reasons, an insurance producer or agency hiring an outside third party to provide the wellness services on a no-additional-fee basis that the insurance producer or agency may not directly or personally provide, also would constitute a prohibited practice.

The Department, therefore, cautions against any direct or indirect provisions by an insurance company, producer or agency of such services or programs at no additional charge to the customer, to avoid violating §375.936(9), RSMo and the prohibition against unlawful inducements and rebates. Unless the wellness program being offered by the producer or agency is included in the premium rates and specified in the insurance contract being sold, it runs the risk of violating Missouri law.

Chapters 374 and 375 are available in their entirety at:

<http://www.moga.mo.gov/STATUTES/C374.HTM> and

<http://www.moga.mo.gov/STATUTES/C375.HTM>.

Applicable statutes: **Sections 374.046 -374.049, 375.932, 375.934, 375.936, 376.940, and 375.942, RSMo.**

If you have any questions regarding this communication, please contact DIFP at

<http://insurance.mo.gov/help/comments.htm> or call toll-free at 800-726-7390.

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P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-02

Certificates of insurance

Issued Feb. 8, 2010

To: All insurance producers, insurance agencies and insurers licensed to sell property and casualty insurance.

From: John M. Huff, Director

Re: Certificates of insurance

Rescinded and Inoperative

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) has recently received information that some producers have been asked to alter standard certificates of insurance without the knowledge or consent of the insurer. The purpose of this bulletin is to remind licensed property and casualty producers, insurance agencies and insurers of their responsibilities to comply with Missouri law when issuing certificates of insurance.

Generally speaking, certificates of insurance serve only as evidence of insurance in lieu of an actual copy of an insurance policy. Distribution of a certificate of insurance which has been modified without authorization from the insurer or which alters the provisions of the underlying policy violates the Unfair Trade Practices Act (§§375.930 – 375.948, RSMo). Specifically, §375.936(6)(a), RSMo, prohibits an insurer from misrepresenting “the benefits, advantages, conditions, or terms of any policy.” A certificate of insurance that does not match the policy it evidences may be interpreted to add or enhance benefits that are not actually included in the policy of insurance. This can lead to a misunderstanding by the policyholder of the scope and limitations of his or her actual coverage. The only way an insurance producer can be certain that he or she has not varied or misrepresented the terms of the policy is to use the form certificate of insurance authorized by the insurer or to secure the insurer’s pre-approval of the altered certificate.

If the Director determines or believes that an insurer, which under §375.932(3), RSMo, includes individual producers, “has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice, or course of business constituting a violation” of

the Unfair Trade Practices Act, the Director may take administrative or civil enforcement action “for relief authorized under” either §374.046 or §374.048, RSMo. Each practice in violation of the Unfair Trade Practices Act is deemed a level two violation under §374.049, RSMo.

If you have any questions regarding this communication, please contact DIFP at <http://insurance.mo.gov/help/comments.htm> or call toll-free at 800-726-7390.

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P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-03

Premium tax forms

Issued Feb. 24, 2010

To: Authorized insurance companies

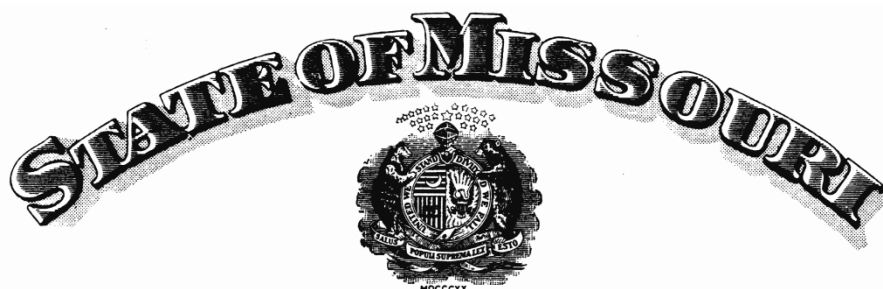
From: John M. Huff, Director

Re: Premium tax form changes

Earlier this month, the Department posted modified forms for insurers to calculate premium taxes for the March 1st filing. These modified forms moved certain tax credits in the calculation of the retaliatory tax. This modification put Missouri's treatment of tax credits at variance from the treatment tax credits receive in other states. The purpose of this bulletin is to withdraw those modified forms and notify companies of the posting of the Department's traditional forms for insurers doing business in Missouri.

The consistent treatment of tax credits throughout the states supports state-based insurance regulation and should be accomplished when statutorily permissible. The Department has concluded that its traditional method of calculating the retaliatory tax is statutorily permissible and preferred.

The Department is aware that some companies have already made their March 1 filing. There is no need for these companies to revise their filings. When the Department reviews these filings, we will make any adjustments necessary to effectuate the filing as if the traditional form had been utilized.



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P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-04

376.391, limits on chiropractic copayments

Issued Sept. 23, 2010

To: Health insurance companies, health services corporations, health maintenance organizations, and chiropractors

From: John M. Huff, Director

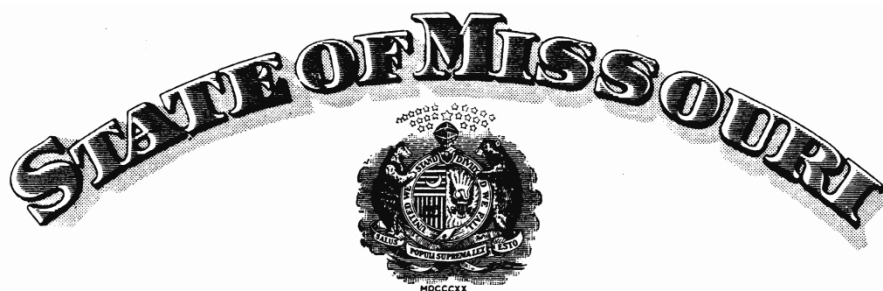
Re: 376.391, limits on chiropractic copayments

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The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) issues this bulletin to remind health carriers of their responsibility to comply with Section 376.391. That section states:

A health benefit plan or health carrier, as defined in section 376.1350, including but not limited to preferred provider organizations, independent physicians associations, third-party administrators, or any entity that contracts with licensed health care providers shall not impose any co-payment that exceeds fifty percent of the total cost of providing any single chiropractic service to its enrollees.

It has come to the attention of the DIFP that some chiropractors who have contacted health carriers regarding the application of this statute have been impermissibly instructed by the carriers to collect a copayment amount that exceeds the statutorily prescribed limitation. Any chiropractor who receives direction from a health carrier to collect a copayment amount in excess of the limitations contained in Section 376.391 may call the DIFP Insurance Consumer Hotline at 800-726-7390 or [file a complaint](#) with the DIFP. These complaints may then be used to determine if there is sufficient cause to warrant a specific market conduct examination.



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INSURANCE BULLETIN 10-05

Patient Protection and Affordable Care Act policy filing guidelines Issued Sept. 23, 2010

To: All insurers authorized to conduct health insurance business in Missouri
From: John M. Huff, Director
Re: Patient Protection and Affordable Care Act policy filing guidelines

Rescinded and Inoperative

The federal Patient Protection and Affordable Care Act (PPACA) requires that health policies issued or renewed after Sept. 23, 2010, contain specific provisions regarding benefits and coverage. Plans in effect prior to March 23, 2010, (grandfathered plans) are also required to include some, but not all, of the required provisions after Sept. 23, 2010. The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) has worked with carriers to implement the PPACA's changes and issues this bulletin to remind carriers of their responsibility to file amendments to their health insurance policy forms to ensure compliance with PPACA standards and to outline the DIFP's requirements for filing revisions relating to PPACA.

Grandfathered health plans

A grandfathered health plan is an existing group health plan, including self-insured plans, or individual health insurance coverage that had at least one enrollee as of March 23, 2010. Although many effective dates are delayed for grandfathered group and individual health plans, PPACA requires grandfathered plans to comply with the following provisions for plan years beginning on or after Sept. 23, 2010:

- Prohibition on lifetime limits for essential health benefits
- Prohibition on rescissions
- Extension of coverage for dependents if the adult child is not eligible for employment-based health benefits
- Grandfathered group health plans will also be required to comply with annual limits on essential health benefits and pre-existing condition exclusions for children 19 years of age or younger

No lifetime limits

Group health and individual health plans may not contain lifetime limits on the dollar value of essential health benefits. Essential benefit categories are provided later in this bulletin.

Restrictions on annual limits

Prior to Jan. 1, 2014, group and individual health plans may only contain restricted annual limits on the dollar value of essential benefits. Annual limits for essential benefits are limited to:

- \$750,000 for plan years beginning 9/23/2010 - 9/22/2011
- \$1.25 million for plan years beginning 9/23/2011- 9/22/2012
- \$2 million for plan years beginning 9/23/2012 – 12/31/2013

Essential benefits

The Secretary of HHS shall define the essential health benefits by federal regulation, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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HHS will take into account a plan or issuer's good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan or policy years beginning before the issuance of regulations defining the term. A plan or issuer must apply the definition of essential health benefits consistently.

Prohibition on rescissions

Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Notification must be made to policyholders prior to cancellation.

Coverage of preventive health services without cost-sharing

Plans must provide coverage without cost-sharing for:

- Services recommended by the U.S. Preventive Services Task Force

- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

Extension of adult dependent coverage

Plans that provide dependent coverage must extend coverage to adult children up to age 26. For plan years beginning before 2014, grandfathered group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage. PPACA does not require carriers to cover children of adult dependents.

Pre-existing condition exclusions

A plan may not impose any pre-existing condition exclusions for individuals age 19 and under. According to HHS, the term "pre-existing condition exclusion" applies to both a child's access to a plan and to his or her benefits once he or she is in the plan.

Patient protections

A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians and obstetrician/gynecologists.

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Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.

A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat the authorization as the authorization of a primary care provider.

Appeals process

Under PPACA the Secretary of the U.S. Department of Health and Human Services and Secretary of the U.S. Department of Labor have established minimum standards for internal appeal and external review processes and will determine whether state standards meet or exceed those federal standards.

Provision of additional information

All plans must submit to the Secretary of HHS and the Director of the DIFP and make available to the public the following information in plain language:

- Claims payment policies and practices
- Periodic financial disclosures

- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to out-of-network coverage
- Information on enrollee and participant rights
- Other information as determined appropriate by the Secretary of HHS

DIFP review of PPACA health insurance filings

The DIFP will review health insurance filings on an EXPEDITED basis if:

- The filing is identified as a PPACA filing, pursuant to the SERFF filing requirement;
- An endorsement/amendment is filed to be used with previously approved forms;
- Only modifications relating to PPACA are included; and
- The filing includes a listing of the form numbers and approval dates of all previously approved forms that will be amended pursuant to the SERFF PPACA checklist.

Filings that include additional modifications and/or benefit changes not directly related to PPACA requirements cannot be given expedited review. Complete policy submissions will not be given expedited review.

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Please be advised that whenever state laws are more favorable to the enrollee, federal requirements are to be considered a 'floor' for the application of benefits. State laws are not pre-empted whenever the application of state requirements does not impede the application of federal law.

If you have any questions regarding this communication, please contact Molly White in the Life and Healthcare Section at 573-526-4106 or Molly.White@insurance.mo.gov.



DEPARTMENT OF INSURANCE, FINANCIAL
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P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-06

Open enrollment periods for carriers issuing child-only policies

Issued Oct. 12, 2010

To: All insurers authorized to conduct health insurance business in Missouri
From: John M. Huff, Director
Re: Open enrollment periods for carriers issuing child-only policies

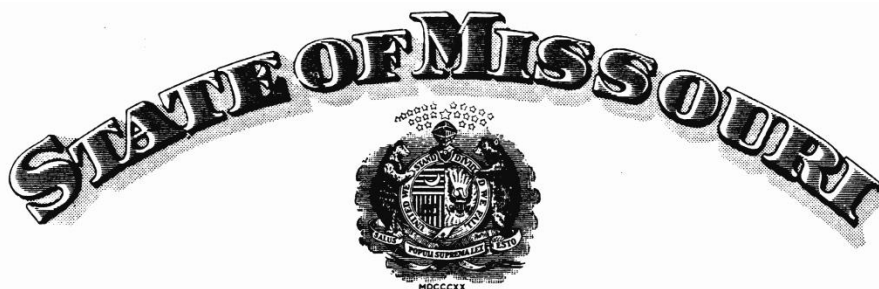
The Affordable Care Act provides that carriers that issue group or individual coverage may not impose pre-existing condition exclusions for children under age 19 for policies beginning or renewed on or after Sept. 23, 2010. The PPACA does not prohibit the carrier from assessing premium based on the health of the child. As a result of these changes, several of the major health insurance carriers in Missouri have stated their intent to withdraw from the state's child-only policy market.

The department expects carriers in the individual health insurance market to provide guaranteed issue coverage to children throughout the year. Alternatively, carriers in the individual market may provide an open enrollment period for children under age 19 on a guaranteed issue basis without any pre-existing condition exclusions. [HHS has issued guidance](#) stating that carriers in the individual market may restrict enrollment of children under age 19 to specific open enrollment periods if allowed under state law.

Missouri law permits carriers to create specific open enrollment periods. Should carriers elect to do so, the department expects carriers issuing child-only policies on or after Sept. 23, 2010, to hold a transitional open enrollment period from Sept. 23 to Dec. 31, 2010, with coverage effective the first of the month following the date of application. During this open enrollment period, all children under the age of 19 shall be offered coverage on a guaranteed issue basis, without limitations or riders based on health status.

The department also expects such electing carriers to hold a yearly open enrollment period during the month of March each year, beginning March 1, 2011, with an effective date of April 1 of the same year. These open enrollment periods will not limit the ability of carriers from enrolling children at other times, if a qualifying event occurs, such as birth, adoption, death, marriage or divorce. Carriers electing to create an open enrollment period are still prohibited from applying pre-existing condition exclusions for children under 19 outside of these open enrollment periods.

If you have any questions regarding this communication, please contact Jamie Morris in the Market Regulation Division at 573-751-3365 or James.Morris@insurance.mo.gov.



DEPARTMENT OF INSURANCE, FINANCIAL
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P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 10-07

Rebating, value-added services, charitable contributions, consumer gifts
Issued Nov. 5, 2010

To: All licensed insurers, all licensed producers, agencies, third-party administrators, trade associations, and the public

From: John M. Huff, Director

Re: Rebating, value-added services, charitable contributions and consumer gifts

Rescinded and Inoperative

Earlier this year, the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) issued [Bulletin 10-01](#) to provide guidance to individual insurance producers (producers) and business entity insurance producers (agencies) regarding the provision of wellness programs under the anti-rebating statutes. Since the release of that bulletin, the DIFP has received many additional inquiries about compliance with the anti-rebating statutes. The DIFP recognizes that the nature of services that an insurance producer may provide in connection with the sale or service of insurance continues to evolve and recognizes the importance of value-added services that producers and agencies provide. This bulletin is being issued in an effort to provide further guidance to producers and agencies concerning the application of the anti-rebating statutes to producers or agencies providing value-added services, making charitable contributions, or providing gifts to consumers.

Rebating

While separate statutes prohibiting rebating exist for life and health insurance (§376.500) and property and casualty insurance (§379.356), the general statute regarding rebating for all lines of insurance is found in §375.936(9) of Missouri's version of the NAIC Model *Unfair Trade Practices Act*. Paragraph (a) of subdivision (9) defines what constitutes a "rebate." Since the paragraph is very long and complicated, it may be helpful to break it into its three primary clauses in order to better understand the meaning. Under §375.936(9)(a), a "rebate" is:

1. knowingly permitting or offering to make or making any contract of life insurance, life annuity, accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or
2. paying or allowing, or giving or offering to pay, allow, or give (directly or indirectly) as inducement to such insurance or annuity,
 - any rebate of premiums payable on the contract, or
 - any special favor or advantage in the dividends or other benefits thereon, or
 - any valuable consideration or inducement whatever not specified in the contract; or
3. giving, or selling, or purchasing or offering or to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith,
 - any stocks, bonds or other securities of any insurance company or other corporation, association, or partnership, or
 - any dividends or profits accrued thereon, or
 - anything of value whatsoever not specified in the contract.

For the purposes of this bulletin, the criteria set forth in the above statutory provisions might be best summarized by answering the following two questions:

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1. Is the item being provided to an insured or prospective insured outside the provisions of the insurance contract?
2. Is the item being provided to an insured or prospective insured intended to induce the purchase of an insurance contract?

If the answer to **both** of these questions is “yes,” the item being provided is likely a rebate.

Value-added services

Following the release of Bulletin 10-01 regarding wellness programs, the DIFP received numerous questions as to what types of value-added services may be provided by producers and agencies. The discussion of value-added services in this bulletin is not intended to supersede Bulletin 10-01, but is to be considered a supplement to that bulletin.

The following non-exclusive list of services, if appropriate in scope, are directly related to the insurance product being sold, intended to reduce claims, and provided in a fair and nondiscriminatory way, would generally not be prohibited by Missouri’s rebating statutes:

- Risk assessments, including identifying sources of risk and developing strategies for eliminating or limiting those risks
- Insurance consulting services such as examining, appraising, reviewing or evaluating the insurance provided
- Claim filing assistance, including the preparation of claim forms
- Certain services related to HIPAA, such as assistance in obtaining a certificate of creditable coverage from a prior carrier for an insured or applicant
- Certain services performed pursuant to COBRA such as billing former employees, collecting insurance premiums and forwarding the aggregate premiums to the employer policy or contract holder or to the insurer when offered in connection with the provision of accident and health insurance to all clients
- Insurance-related regulatory and legislative updates
- Providing information to group policy or contract holders and members under group insurance policies currently in place, as well as the forms needed for group insurance plan administration, enrollment in a group insurance plan, insurer Web links (including, for example, access through a website created by the insurance producer to an employee benefit portal that contains such information) and answers to frequently asked questions relating to insurance.

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The following non-exhaustive list of services, if provided for free or at a reduced cost and not specified in the insurance contract being sold, could be viewed by the DIFP as violations of Missouri's anti-rebating statutes:

- Services related to employee compensation, discipline, job descriptions, leaves of absence, organizational development, business policies and practices, safety, staffing and recruiting that are used as an inducement to the purchase of insurance and are unrelated to risk management.
- Risk management or loss control services (1) that are not routinely available to all agency clients or (2) that exceed the insurance-related risk evaluation and underwriting of an account or (3) that are frequently provided on a fee for service basis
- Payroll services, such as providing employers with check creation and distribution services for their employees
- Referrals to third-party service providers through which an insured or prospective insured may receive a discounted rate contingent upon the purchase or renewal of insurance
- COBRA administration that goes beyond billing and collecting the insurance premiums for former employees that are to be forwarded to the contract holder or insurer
- Establishment and administration of employer-sponsored cafeteria plans, flexible spending accounts, and health reimbursement accounts
- General tax preparation or accounting services
- Legal services.

Please be advised that the preceding lists are not exclusive and are instead intended for illustrative purposes. Complaints regarding inducements and rebates are extremely fact-sensitive, and the DIFP will consider each situation on a case-by-case basis.

Charitable contributions

Insurance producers or agencies may contribute to charities, as long as such contribution is not made as an inducement to the purchase of insurance. The DIFP will investigate any questions or complaints that arise concerning charitable contributions on a case-by-case basis. Some of the factors that the DIFP will review in determining the acceptability of a charitable contribution are:

- The timing of the contribution
- The amount of contribution
- The producer/agency's history of giving
- The relationship between the producer/agency and the contribution recipient.

Consumer gifts

Gifts to a consumer of any value are prohibited if the gift is an inducement to, or conditioned upon, the purchase or renewal of an insurance policy. If it is unrelated to the purchase of insurance, a small item with a low fair market value may generally be given. Again, the DIFP will consider each complaint regarding gifts on a case-by-case basis.

Chapters 374, 375, 376 and 379 are available in their entirety at:

<http://www.moga.mo.gov/STATUTES/C374.HTM>,

<http://www.moga.mo.gov/STATUTES/C375.HTM>,

<http://www.moga.mo.gov/STATUTES/C376.HTM>, and

<http://www.moga.mo.gov/STATUTES/C379.HTM>.

Applicable statutes: Sections 374.046 -374.049, 375.932, 375.934, 375.936, 376.940, 375.942, 376.500, and 379.356, RSMo.

If you have any questions regarding this bulletin, please [contact DIFP](#) or call toll free at 800-726-7390.